Missouri Medicaid School District Direct Service Training

Supplemental Material

MEDICAID PROGRAM RESOURCES

Informational Resources available at www.dss.mo.gov/dms

CONTACTING MEDICAID

The following phone numbers are available for Medicaid providers to call the Provider Communications Unit with provider inquiries, concerns or questions regarding proper claim filing, claims resolution and disposition, and recipient eligibility questions and verification. The toll free line provides an interactive voice response system that can answer questions regarding matters including recipient eligibility, last two check amounts, claim status and procedure code status. Providers must use a touchtone phone to access the system.

Provider Communications	800/392-0938
Interactive Voice Response (IVR)	800/392-0938
Standard Line	573/751-2896

The Provider Communications Unit also processes written inquires. Written inquiries should be sent to:

Provider Communications Unit
Division of Medical Services
PO Box 6500
Jefferson City, Missouri 65102

573/635-3559
Call this number for assistance in establishing the required electronic claims and remittance advice formats, network communication, HIPAA trading partner agreements and assistance with the Verizon Internet billing service.

Providers can contact Provider Enrollment via email as follows for questions regarding enrollment applications: providerenrollment@mail.medicaid.state.mo.us

Changes regarding address, ownership, tax identification number, name (provider or practice), or Medicare number must be submitted in writing to:

Provider Enrollment Unit
Division of Medical Services
PO Box 6500
Jefferson City, Missouri 65102

573/751-2005
Call the Third Party Liability Unit to report injuries sustained by Medicaid recipients, problems obtaining a response from an insurance carrier, or unusual situations concerning third party insurance coverage for a Medicaid recipient.

573/751-6683
Provider Education Unit staff are available to educate providers and other groups on proper billing methods and procedures for Medicaid claims. Contact the Unit for training information and scheduling.

800/392-2161 or 573/751-6527
The Recipient Services Unit assists recipients regarding access to providers, eligibility, covered and non-covered services and unpaid medical bills.

800/392-8030
Providers can call this toll free number to initiate an emergency request for an essential medical service or an item of equipment that would not normally be covered under the Medicaid program, or to request a drug prior authorization. The Medicaid exceptions fax line for non-emergency requests only is 573/636-6470.

The Division of Medical Services (DMS), in cooperation with Verizon Information Technologies, has an Internet service for Missouri Medicaid providers. Missouri Medicaid providers have the ability to:

- Submit claims and receive claim confirmation files;
- Verify recipient eligibility;
- Obtain remittance advices (RAs);
- Submit Adjustments;
- Submit attachments; and
- View and download public files.

The web site address for this service is Without proper authorization, providers are unable to access the site. Only providers who are approved to be electronic billers can enroll and utilize the web site services. To participate in the service, the provider must apply on-line at http://www.medicaid.state.mo.us/Application.html. Each user is required to complete this on-line application in order to obtain a user ID and password. The application process only takes a few minutes and provides the applicant with a real-time confirmation response, user ID and password. Once the user ID and password have been received, the user can begin using the www.emomed.com website. The password can be changed to one of the user's own choice.

Questions regarding the completion of the on-line Internet application should be directed to the Verizon Information Technologies Help Desk, (573) 635-3559.

An authorization is required for each individual person within a provider's office or a billing service who will be accessing the Internet site.

Providers can access Missouri Medicaid recipient eligibility files via the web site. Functions include eligibility verification by recipient ID, casehead ID and child's date of birth, or Social Security number and date of birth. Eligibility verification can be performed on an individual basis or in a batch file. Individual eligibility verification occurs in real-time basis similar to the Interactive Voice Response System, which means a response is returned immediately.

The Medicaid program is phasing out the mailing of paper Remittance Advices (RAs). Providers no longer will receive both paper and electronic RAs. If the provider or the provider's billing service currently receive an electronic RA, (either via the emomed.com Internet website or other method), paper copies of the RA are discontinued as of July 20, 2004. Providers and billers are encouraged to move to the Internet to receive RAs.

Receiving the Remittance Advice via the Internet is very beneficial to a provider's or biller's operation. With the new Internet RA, a user can:

- Retrieve the RA the Monday following the weekend claim processing cycle (two weeks sooner than receipt of the paper RA);
- Have access to RAs for 62 days (the equivalent of the last four cycles);
- View and print the RA from the desktop; and,
- Download the RA into the provider's or biller's operating system for retrieval at a later date.

The new Internet RA will be viewable and printable in a ready to use format. Just point and click to print the RA or save it to the computer system for printing at the user's convenience.

If the provider or the biller receives a paper copy of the RA only and not an electronic copy, please consider moving to the Internet to receive the RAs. To sign up for this new feature, see the instructions at the beginning of this information.

Please note – once signed up to receive the RAs via the Internet, receipt of paper RAs by the provider or a billing service will be discontinued.

Providers have options on the Internet Medical, Dental, Inpatient, Outpatient and Nursing Home claims for a "Frequency Code" that will allow either a 7 – Replacement (Adjustment) or an 8 – Void (Credit). This will control an individual adjustment or void, but not group adjustments or voids. Claim adjustments and credits can be submitted by utilizing the CLM, field CLMO5-3, segment of the 837 Health Care Claim.
Several public files are available for viewing or downloading from the web site including the claims processing schedule for the State fiscal year which begins July 1 and ends June 30. Providers also have access to a listing of the Adjustment Reason Codes and Remittance Advice Remark Codes.

- **www.dss.mo.gov/dms**
  - Adjustment Reason and Remark Codes
  - Apply for Internet Access
  - Medicaid Program Information
  - Frequently Asked Questions
  - Provider Manuals
    - Therapy Manual
      - Documentation - Section 13.5, 13.15, 13.16, 13.17 and 13.17a
      - Claim form billing instructions - Section 15
    - Internet Billing Instructions
    - Cycle Run Schedule
  - Bulletins
    - January 16, 2003
    - June 30, 2003
    - March 31, 2004

- Claim Billing
- Eligibility
- Obtain Remittance Advice and Check amounts
- Check Claim Status
- Cycle Run Schedule

Documentation

➢ Plan of Care

- **Diagnosis**
- **Desired Outcome**
- **Nature of treatment**
- **Frequency**
- **Duration**

➢ Progress Notes

- **Complete Name**
- **Date of Service**
- **Actual treatment provided**
- **Individual or group**
- **Actual time delivered**
- **Signature of therapist performing therapy**

A current referral/prescription/IEP from the child's primary care provider which lists the Missouri Medicaid Provider number.

Documentation must be made at the time services are delivered.

PLEASE DO NOT STAPLE IN THIS AREA

APPROVED OMB-0938-0008

CARRIER

HEALTH INSURANCE CLAIM FORM

PICA

1. MEDICARE (Medicare #)	MEDICAID (Medicaid #)	CHAMPUS (Sponsor's SSN)	CHAMPVA (VA File #)	GROUP HEALTH PLAN (SSN or ID)	FECA BLK LUNG (SSN)	OTHER (ID)	1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)
							18111511

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	3. PATIENT'S BIRTH DATE MM DD YY / SEX	4. INSURED'S NAME (Last Name, First Name, Middle Initial)
RICKARD, REBECCA	M F	
5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED: Self, Spouse, Child, Other	7. INSURED'S ADDRESS (No., Street)
CITY / STATE	8. PATIENT STATUS: Single, Married, Other; Employed, Full-Time Student, Part-Time Student	CITY / STATE
ZIP CODE / TELEPHONE (Include Area Code) ( )		ZIP CODE / TELEPHONE (INCLUDE AREA CODE) ( )
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:	11. INSURED'S POLICY GROUP OR FECA NUMBER
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES NO	a. INSURED'S DATE OF BIRTH MM DD YY / SEX M F
b. OTHER INSURED'S DATE OF BIRTH MM DD YY / SEX M F	b. AUTO ACCIDENT? YES NO / PLACE (State)	b. EMPLOYER'S NAME OR SCHOOL NAME
c. EMPLOYER'S NAME OR SCHOOL NAME	c. OTHER ACCIDENT? YES NO	c. INSURANCE PLAN NAME OR PROGRAM NAME
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. RESERVED FOR LOCAL USE	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

14. DATE OF CURRENT: MM DD YY — ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)	15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM / TO MM DD YY
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE	17a. I.D. NUMBER OF REFERRING PHYSICIAN	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM / TO MM DD YY
19. RESERVED FOR LOCAL USE		20. OUTSIDE LAB? YES NO / $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. L 3899
2. L ____ . __
3. L 29524
4. L ____ . __

22. MEDICAID RESUBMISSION CODE / ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY / To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS / MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 07 20 04	03		97110 / tm	1	40 00	4	E			
2										
3										
4										
5										
6										

25. FEDERAL TAX I.D. NUMBER SSN EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO	28. TOTAL CHARGE $ 40 00	29. AMOUNT PAID $	30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)	32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)	33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #
SIGNED _____ DATE _____		ANY SCHOOL DISTRICT 488888888 PIN# _____ GRP# _____

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88)

PLEASE PRINT OR TYPE

FORM HCFA-1500 (12-90)
FORM OWCP-1500 FORM RRB-1500

State of Missouri Medicaid

Home

If you are not **becky L. rickard**, please logout.

User: **becky L. rickard**

Provider: 202137709 BPST

Submit Claims Medical (HCFA 1500) Inpatient (UB-92) Outpatient (UB-92) Dental Nursing Home Pharmacy	**Submit Claim Attachments** Certificate of Medical Necessity Sterilization Consent Second Surgical Opinion Acknowledgement of Receipt of Hysterectomy Information Medical Referral of Restricted Recipient (SURS 118)
Update Submitter/Provider Information	Send Files Send Test File Send HIPAA Test File
Daily Claims Summary	**Receive HIPAA Test Files** NCPDP(Test) RA 835(Test) FA 997(Test) CC (Test) Elig 271(Test) Clm St 277(Test)
Verify Recipient Eligibility By Subscriber ID, SSN, Name, or Casehead ID	View Claim Status Check Inquiry Drug PA
Receive Provider Files Claim Confirmation Eligibility Verification Printable Remittance Advice (RA) Remittance Advice(835) Proprietary Remittance Advice Functional Acknowledgement(997) NCPDP Eligibility Verification(271) Response Claim Status(277) Response	**Public Files** Explanation of Benefits Exception List Claims Processing Schedule ADD/REMOVE Internet Provider Form (PDF)
State of Missouri Medicaid Manuals	Contact Us

[Help]

State of Missouri Medicaid

Medical Claim

If you are not **becky L. rickard**, please logout.

User: **becky L. rickard**

Provider:

Fields marked * must be filled in.

Patient's I.D. *	Patient's Name * (Last Name, First Name)
Related Causes Code:	Claim Frequency Type Code:
LMP Date (mm/dd/yy) / /	I.D. Number of Referring Physician
Hospitalization Dates Related to Current Services From (mm/dd/yy) / / To (mm/dd/yy) / /	Service Facility Location?
Diagnosis or Nature of Illness or Injury (Do not include the decimal) 1. * 2. 3. 4.	Medicaid Resubmission*

	A	B C	D	E F G	H K
	Dates of Service * (mm/dd/yy)	Place of Service *	CPT / HCPCS Procedure Code *	Diagnosis Code * Charges * $	EPSDT Fam. Plan
	From To		Modifiers	Days or Units *	Performing Provider
1.	/ / / /				

Patient Account No.	Total Charge $ 0.00
Other Payer(s)? 1. 2. 3. 4.	Amount Paid 1. 2. 3. 4.
Facility Name	Balance Due $ 0.00

State of Missouri Medicaid

Medical Claim

If you are not **becky L. rickard**, please logout.

User: **becky L. rickard** Provider: **202137709**

Thank you. Your claim has been received.

Insured's I.D. Number 18111511	Patient's Name (Last Name, First Name) RICKARD, REBECCA
Related Causes Code:	Claim Frequency Type Code:
LMP Date (mm/dd/yy)	I.D. Number of Referring Physician
Hospitalization Dates Related to Current Services From (mm/dd/yy) : To (mm/dd/yy) :	Service Facility Location?
Diagnosis or Nature of Illness or Injury 1. 3899 2. 29524 3. 4.	Medicaid Resubmission

	A	B C	D				E F G		H K
	Dates of Service (mm/dd/yy)	Place of Service	CPT / HCPCS Procedure Code				Diag Code	Charges $	EPSDT Family Plan
	From To		Modifier1	Modifier2	Modifier3	Modifier4	Days or Units		Performing Provider
1.	07/20/04	03	97110				1	40.00	E
	07/20/04		TM				4		

Patient Account No.	Total Charge $ 40.00
Other Payer(s)? 1. 2. 3. 4.	Amount Paid 1. 2. 3. 4.
Facility Name	Balance Due $ 40.00

Next

PROVIDER NUMBER: 200000000 (1) STATE OF MISSOURI MEDICAID RA # 09999999 (3)
MEDICAL (5) REMITTANCE ADVICE AS OF 06-18-04 (2) PAGE 2 (4)

RECIPIENT NAME (6)	MEDICAID I.D. (7)	INTERNAL CONTROL NUMBER (8)	SERVICE DATES FROM MMDDYY (9)	TO MMDDYY (9)	POS (10)	PROC CODE-MOD (11)	QTY (12)	BILLED AMOUNT (13)	ALLOWED AMOUNT (14)	CUT/ BACK (15)	PAYMENT AMOUNT (16)	ADJUST REASON CODES (17)
KROSS,IMA	09004999	1504160009999	060104	060104	11	99213	1	42.44	24.00	18.44-	24.00	A2
		PAT ACCT: KR025										
		(18)	060104	060104	11	85024	1	35.00	11.70	23.30-	11.70	A2
			060104	060104	11	82948	1	18.00	1.00	17.00-	1.00	A2
			060104	060104	11	83036	1	40.00	13.41	26.59-	13.41	A2
			060104	060104	11	80061	1	50.00	18.51	31.49-	18.51	A2
			****CLAIM TOTALS :				5		68.62		68.62	
								185.44		116.82-		
*** REMARK CODES: N59												
(19)												
JONES,MARY	05513849	4404168009898	061504	061504	11	99213	1	45.00	24.00	21.00-	24.00	A2
		PAT ACCT: JO398										
		(18)	061504	061504	11	82948	1	18.00	1.00	17.00-	1.00	A2
			061504	061504	11	36415	1	4.00	.00	4.00-	.00	125
			****CLAIM TOTALS :				3		25.00		25.00	
								67.00		42.00-		
*** REMARK CODES: N59 MA66												
(19)												
SMITH,JOHN	29030841	1504161006789	052404	052404	11	99213	1	42.44	24.00	18.44-	24.00	A2
		PAT ACCT: SM145										
			052404	052404	11	81003	1	12.00	.00	12.00-	.00	125
			****CLAIM TOTALS :				2		24.00		24.00	
								54.44		30.44-		
*** REMARK CODES: MA66												
(19)												
SMITH, WILL	77889911	1504166000987	060704	060704	11	99213	1	42.00	.00	42.00-	.00	22
***REMARK CODES: MA92												
(19)												

CORRECTED PRIORITY PAYER NAME: (20) DMS HEALTHCARE
OTHER CLAIMS RELATED ID: (21) AA345678
OTHER CLAIMS RELATED ID: (22) 555495755

****CATEGORY TOTALS :	NUMBER OF CLAIMS =	4	11		117.62		117.62	
(23)				348.88		231.26-		
****PROVIDER TOTALS :	NUMBER OF CLAIMS =	4	11		117.62		117.62	
(24)				348.88		231.26-		

SPENDDOWN AMOUNT: .00
(25)

** EARNINGS DATA ***		CURRENT	
(26)	NO. OF CLAIMS PROCESSED	75	
	DOLLAR AMOUNT PROCESSED	1,752.71	
	CHECK AMOUNT		1,752.71

MISSOURI MEDICAID
INDIVIDUAL ADJUSTMENT REQUEST

[X] UNDERPAYMENT

[ ] OVERPAYMENT

FORWARD ORIGINAL TO:

DIV. OF MEDICAL SERVICES
ADJUSTMENT UNIT
P.O. BOX 6500
JEFFERSON CITY, MO 65102

TO FACILITATE PROCESSING, PLEASE ATTACH THE FOLLOWING:

1. Claim Copy
2. Remittance Advice Copy

PLEASE ENTER THE FOLLOWING DATA FROM YOUR REMITTANCE ADVICE

3. INTERNAL CONTROL NUMBER: 1 5 0 3 2 7 9 0 0 0 0 0 0

4. RECIPIENT MEDICAID NUMBER: 18111511

5. PROVIDER LABEL:
ANY SCHOOL DISTRICT
48888888

6. RECIPIENT NAME: RICKARD, Rebecca

7. REMITTANCE ADVICE DATE: 11-23-03

R.A. PAGE NUMBER:

REFER TO PROVIDER MANUAL ADJUSTMENT SECTION FOR INSTRUCTIONS

		SERVICE DATE	INFORMATION ON REMITTANCE ADVICE	CORRECTED INFORMATION
8.	QTY/UNITS	10-30-03	1	4
9.	NDC/PROCEDURE CODE			
10.	SERVICE DATE(S)			
11.	BILLED AMOUNT		$10.00	$40.00
12.	PAID AMOUNT			
13.	PATIENT SURPLUS			
14.	OTHER RESOURCES (TPL) (IDENTIFY SOURCE)			

15. OTHER/REMARKS

Billed incorrect number of units and dollar amount.

16. PROVIDER'S SIGNATURE: Bill Error TITLE

DATE: 06-30-04

MO-9810 (12-00)

CLAIMS PROCESSING SCHEDULE
FOR STATE FISCAL YEAR 2005

Friday, June 18, 2004	Tuesday, July 6, 2004
Friday, July 9, 2004	Tuesday, July 20, 2004
Friday, July 23, 2004	Thursday, August 5, 2004
Friday, August 6, 2004	Friday, August 20, 2004
Friday, August 20, 2004	Tuesday, September 7, 2004
Friday, September 10, 2004	Monday, September 20, 2004
Friday, September 24, 2004	Tuesday, October 5, 2004
Friday, October 8, 2004	Wednesday, October 20, 2004
Friday, October 22, 2004	Friday, November 5, 2004
Friday, November 5, 2004	Monday, November 22, 2004
Friday, November 19, 2004	Monday, December 6, 2004
Friday, December 3, 2004	Monday, December 20, 2004
Friday, December 17, 2004	Wednesday, January 5, 2005
Friday, January 7, 2005	Thursday, January 20, 2005
Friday, January 21, 2005	Monday, February 7, 2005
Friday, February 4, 2005	Monday, February 21, 2005
Friday, February 18, 2005	Monday, March 7, 2005
Friday, March 11, 2005	Monday, March 21, 2005
Friday, March 25, 2005	Tuesday, April 5, 2005
Friday, April 8, 2005	Wednesday, April 20, 2005
Friday, April 22, 2005	Thursday, May 5, 2005
Friday, May 6, 2005	Friday, May 20, 2005
Friday, May 20, 2005	Monday, June 6, 2005
Friday, June 3, 2005	Monday, June 20, 2005

*The Cycle Run Dates are tentative dates calculated by the Division of Medical Services. The dates are subject to change without prior notification.

*All claims submitted electronically to Verizion, must be received by 5:00 p.m. of the Cycle Run/Remittance Advice date in order to pay on the corresponding check date.

Holidays For State Fiscal Year 2005

July 5, 2004 Independence Day	December 31, 2004 New Years Day
September 6, 2004 Labor Day	January 17, 2005 Martin Luther King Day
October 11, 2004 Columbus Day	February 11, 2005 Lincoln's Birthday
November 11, 2004 Veteran's Day	February 16, 2005 Washington's Birthday
November 25, 2004 Thanksgiving	May 9, 2005 Truman's Birthday
December 24, 2004 Christmas	May 30, 2005 Memorial Day